

AZ Body-Mind Counseling
Art Matthews, MA LPC
4111 E Valley Auto Dr., Ste. 201
Mesa, AZ 85206
480-238-5841

Authorization for Release of Information

Student's Name _____ Birth Date _____
Last Name First Name Initial
Maiden Name, if applicable _____

This will authorize:

Disclosing Representative and Business Name _____
Business Address _____
City/State/ZIP _____
Phone/FAX _____ FAX _____

To release information to:

Recipient Name _____
Business Address _____
City/State/ZIP _____
Phone/FAX _____ FAX _____

The following information:

_____ To include: HIV/AIDS _____ Drug/alcohol _____
Initial Initial

For the purpose of: _____

AUTHORIZATION: I certify that this request was made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by notifying the therapist in writing. I understand any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider, the released information may not be protected by federal privacy regulations. This authorization will expire 180 days from the date of signature unless otherwise stated.

Signature of Client

Date

Signature of Client

Date